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## Irish Healthcare; The Evidence on Communicating Policy.

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**Session 10: Issues in Comparative Public Administration**

**IRISH HEALTH CARE; THE EVIDENCE ON COMMUNICATING POLICY**

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## **Abstract:**

### **IRISH HEALTH CARE; THE EVIDENCE ON COMMUNICATING POLICY**

The complexity of the health care environment necessitates that health policy, legislative objectives, resource allocation models, and management structures be aligned to plan and deliver healthcare services strategically. Policy in the Irish health care system is guided by the National Health Strategy of 2001; in that there should be equitable distribution of health services focused on the need of the citizen-client. Though the Health Strategy uses the words ‘evidence based’, ‘population health’, ‘equity’, ‘people-centred’ and ‘health and social gain’, there is little evidence that these concepts have gained purchase in the present implementation of policy and planning in Irish health care (Byers 2009). Health policy in the last five years, in terms of the statements made and the actions taken by the Minister for Health and Children, runs counter to the national strategy; in terms of advocating increased provision of private health care facilities in the acute care sector and their subsidisation by the state both financially and through the provision of public lands as well as through the increased centralisation of health care structures with reduced transparency.

This paper reports on a study of policy and planning in the health care sector. It considers the ambiguity of a national health care strategy crafted to underpin such planning in health care service delivery and espousing the principles of ‘people centredness’ and ‘equity’ and health policy implementation on the ground. Reflecting on these tensions in the Irish health care system, this paper notes the difficulties that can be created for the stakeholders in the system both in access to, and in the planning and management of health care services. The paper also draws on the Canadian experience as a comparator, where the pursuit of citizen-centred policy, has stimulated innovative approaches to the organizational design of governments’ service delivery systems (Flumian, Coe and Kernaghan 2007).

## **Introduction**

This paper seeks to examine the implementation, and thus communication of Irish healthcare policy in the health services over the past decade through the vehicle of health services planning. O’Ferrall (2008) contends that in the Irish context ‘...public policy outcomes are generally poor, but starkly so in healthcare, in large part because of the democratic deficit in the formulation and implementation of such policies’. This paper draws on fieldwork in the planning and management of the health care services in Ireland. Two key stumbling blocks to successful implementation of healthcare policy include the limitations of the legislation underpinning the planning and management of the health services and the lack of recognition of the complexity of the healthcare environment and the stakeholders within it, in attempting to implement policy. A number of issues are explored in this paper through a review of

legislation and key documentation, as well as drawing upon some field research in the Irish healthcare system. The paper also utilises some fieldwork reporting on the Canadian experience as a comparator, in which the citizen-client plays a much more active role in both the formulation and implementation of healthcare policy.

The complexity of the health care environment necessitates that legislative objectives, resource allocation models, management structures and health policy be aligned to plan and deliver healthcare services strategically. The findings of this paper suggest that the Irish policy of administrative control has changed little in the last decade, despite the advent of a national strategy, planning legislation and structural reform. There is no evidence of a push to encourage accountability other than financial, and the health service continues to be subject to the sway of producer and political interests.

Service delivery to the citizen-client should be the end-goal of our health services, given that our National Health Strategy is replete with promises of people-centredness and equity. McKevitt (1998:45) questions ‘what is the strategic intent of health care policy and how does Ireland’s strategy stand up to comparison with that of other modern economies?’ This paper seeks to learn from the Canadian experience in this regard.

### **Drawing the Context; the Irish Health Care System**

The Irish health care system is described as an integrated healthcare system. The Government, the Minister for Health and Children and the Department of Health and Children (DOHC) are at the head of health service provision in Ireland. This health service provision is publicly funded through taxation. Until 2005, the Irish healthcare sector comprised a health board management structure, 11 health boards in all, it is now replaced by health regions with local health offices (which follow the outlines of the original health boards geographically) managed centrally by the Health Services Executive (HSE) and is described as an integrated public health care system. The HSE is now the main provider of health and personal social care. The formation of the HSE was the result of the most significant and recent reform programme in Irish health services delivery. To summarise the Irish health care structure as per the OECD (2008;287) review; the ‘HSE is responsible for the management and delivery of health and personal social services within the policy,

legislative and resource allocation framework determined by the Minister for Health and Children and the government.’ Therefore, the CEO of the HSE is the Accounting Officer for expenditure but the Minister is politically accountable for the implementation of policy by the HSE as well as the overall performance of the health service.

Planning in the Irish healthcare system for delivery and management of services is underpinned by policy derived at the level of the Department of Health and Children. Reform in the health services over the past decades has been aimed at removing the DOHC’s involvement from the day to day workings of the health service and returning its function back to that of devising policy and preparing legislation. Strategic planning at a national level is the responsibility of the Health Services Executive (HSE) in terms of a National Service Plan (NSP) and a three year corporate plan, taking cognisance of the DOHC’s policy and strategy for the Health Service as a whole. Due to budgetary constraints and a myriad of competing demands, it is crucial in healthcare to be able to identify and prioritise health needs and develop services. In order to achieve this healthcare management and planning needs to be underpinned by a clear strategy and vision. In the Irish healthcare context that strategy and policy is meant to be guided by the National Health Strategy of 2001 (Quality and Fairness; A Health System for You) and facilitated in its delivery by the Health Reform Programme (2003).

In this paper, the use of the Canadian experience provides an interesting comparator to the Irish health care reform programme and Irish healthcare policy. Canada’s health care system is highly decentralised with the provinces (and territories) primarily responsible for health care (Marchildon 2005). Most public health services are organised or delivered by regional (or district, in the case of Nova Scotia) health authorities that have been delegated the responsibility to administer services within defined geographic areas by their ministries of health at a provincial level. The Canadian system would also be described as an integrated public health care system. For the purposes of this paper the Capital Health District Health Authority (DHA) in Nova Scotia is used as a comparative case. This forms an interesting contrast with the health regions and their local areas (Health Boards prior to 2005) in the Irish situation. In comparison to the Irish developments which focus on increased centralisation of services into one national Health Services Executive (HSE), the Canadian system has developed in a decentralised fashion with local control and consumer choice.

## **An overview of Irish health policy and legislation**

Irish Health Policy has been represented for the past 10 years by the National Health Strategy; Quality and Fairness, A Health System for You (2001). Wiley's (ESRI) critique in 2001 emphasised the need for a new health strategy to address the issue of growing socio-economic inequalities. According to Bond and Cuniffe (2002) this second National Health Strategy was drawn up to address this crucial concern also identified in the Irish health services by the DOHC; that of equity. This principle along with three other key principles of the strategy; quality, accountability and people-centeredness were to underpin planning and management of the Irish health services. Another focus of the Strategy that has particular pertinence to a comparison with the Canadian case was the adoption of a population health approach (Wilde 2001). The Canadian health system has embraced this concept (Davies 2002, Public Health Agency 2005), which recognises that many factors exert a strong influence on health and that intersectoral collaboration and promoting public participation are crucial for strategic planning. In the Irish case this approach has yet to be incorporated in the health management process.

However 10 years on, many of the goals and objectives of the National Health Strategy have not yet been implemented and have little influence on the planning at the front line or the policy espoused by the Minister for Health & Children. The Strategy (2001a:53) had identified problems with organisational issues in the health services. It pointed to the problems with the role and functions of the health boards; in particular, achieving a balance between local and national decision making and the need to achieve greater clarity with regard to the levels at which decision making occurs. In order to deal with these issues in more detail a number of reports were commissioned by the DOHC. In June 2003, the Prospectus group of consultants reported on their review of the structural and organisational elements and recommended structural reform of the organisation of the health system. Their findings focused on the complex and fragmented structures in the health system and the need for rationalisation of certain agencies. In terms of supporting processes, service planning was a focus, with a recommendation for its strengthening and alignment to new structures. The need for service evaluation, stakeholder participation, integration and a formal performance

framework were all emphasised. The key recommendation of the Prospectus Report was system-wide structural reform, comprising a restructured DOHC, which would hand over its executive functions to a new Health Services Executive (HSE). The HSE would be the body through which accountability for all operational matters within the health system would be channelled and would be underpinned by the creation of four regional management structures to replace the health boards.

The legislation providing for the establishment of the HSE; the Health Act 2004, bringing about the first significant reform in the Irish health services passed all stages in the Dáil in a guillotined debate in late December 2004, without time for many provisions to be discussed and fully understood within or outside the Dáil, and even by the government, which promulgated them (Tussing and Wren 2005). There was no previous White Paper outlining the intent of the legislation. Thus, the Health Act [no 42] 2004 focused on the top down application of administrative reforms and did not deal with the issues such as equity, as identified as a core principle to underpin planning by the National Health Strategy. When questioned about this, the Minister for Health & Children responded that adopting a ‘rights based approach’ would result in a citizen-client being able to argue in court for a certain clinical approach which was not desirable and this in effect would remove ‘autonomy from clinical independence to legal independence, as it were’ (Mary Harney, Dáil Debate, December 2004).

The current mission statement of the Department of Health and Children (2010) is as follows:

*To improve the health and well-being of people in Ireland in a manner that promotes better health for everyone, fair access, responsive and appropriate care delivery, and high performance.*

If this vision is to be fundamental to the development of health planning and the organisation of health services, there needs to be a thorough appreciation of what the situation is at the local level and identification of the key stakeholders, who should be consulted and involved in the process. O’Hara (1998) emphasises that devolution of decision-making and planning to front line staff is good in principle, but it also needs to be backed up by a comprehensive

communication system to ensure that information and feedback from those at the coal face of service delivery is brought back to those who are funding and overseeing the strategic direction of the service. The more centralised the system, as is the case in Ireland now, the more difficult this becomes.

In contrast, Canada has a strongly egalitarian, one tier system of health care (Bhatia 2010). The health system also delivers results; life expectancy in Canada for women and men, is nearly two years above that of Irish women and is exactly two years above that for Irish men. (OECD 2005). Underpinning the importance of public participation in health care in Canada is the Social Union Framework signed by all provincial and territorial governments in 1999 (except for Quebec). The framework attempts to reflect and give expression to Canadian's fundamental values. Its relevance to healthcare is the commitment to ensure 'adequate, affordable, stable and sustainable funding for social programs'. Abelson and Eyles (2004) note that it also includes agreement for governments to improve public accountability and transparency by ensuring mechanisms for Canadians to participate in developing social priorities and reviewing health system outcomes.

Crucial to underpinning the delivery of Canadian Health Care are the principles originally set out in the Medical Care Act of 1966, or medicare (with a small "m") as it is referred to in Canada. In comparison to the Irish health legislation at this time (1970 Health Act), the Canadian legislation was underpinned by four key principles; universal coverage, comprehensive services, portability, and public management (Lassey, Lassey and Jinks 1997). The 1984 Canada Health Act reiterated these four key principles and added a fifth; that of reasonable access which have become enshrined in Canadian health care. The Act sets out the primary objective of Canadian health care policy, which is 'to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.' The provinces to qualify for federal support (originally about half of total provincial costs) are required to meet these principles. These elements ensure that all essential services are covered; that everyone is covered and can receive care in any province; and that health care is administered by a nonprofit public agency. The key to the Canadian system is that there is only one insurer -



the government. So, similarly to the Irish system when fiscal cuts are called for, these can be administered at the funding source.

## **Principles and Health Services Planning**

For the principles of a health care system to be put into effect, there must be a coherent planning system. Service (business) planning was introduced into Irish health care back in 1998 and it was described at the time by the DOHC (1998:26) as a ‘strategic management tool’ as it would establish the basic principles of the Strategic Management Initiative, by involving multiple stakeholders in the planning process. The Health Acts of both 1996 and now, 2004 are not specific on how service plans are to be developed. There is no acknowledgement of the strategic principles that would underpin the service planning process, no delineation of the participants, including the citizen-client and the nature of their involvement and no mention of the use of performance indicators in the legislation. Initially service planning became operational at health board level as a set of guidelines and a template.

A welter of publications has emanated in the health arena in the past ten years with a focus on the restructuring of the health services and not on the fundamental issues such as planning evaluation and performance management. The establishment of the HSE and the legislation that underpins service planning does not demonstrate any significant changes to the process that was set up under the 1996 Health (Amendment) Act No. 3. A number of developments including participation by the public on advisory panels are very limited in their prescription and very much within the control of the Minister for Health & Children. The Irish health care system tends to revert to a ‘command and control’ model in planning, management and implementation with little regard for engagement with health professionals, middle management and the citizen-client. This results in a planning system that tends not to engage the hearts and minds of the operating core in the health services and is isolated from the real health needs of the community.

The HSE now underpins its annual service planning with a three year corporate plan. It is guided by six key objectives that differ from the four key principles of the National Health Strategy already outlined. One of the key objectives of the corporate plan that has been

constantly emphasized in the reform programme of the HSE is that of ‘sustainable services’. Its translation according to the HSE is that of reconfiguring services by; co-location of private hospitals on public hospital sites, the National Childrens’ Hospital Project, maintaining an 80:20 Public-Private mix ratio in hospitals where appropriate, developing specialist centres for hospitals and laboratory services, the National Cancer Control Programme, implementation of new consultants (contract), review of the roles of external service contractors, and rolling out additional Primary Care Teams as well as value for money (VFM). Although spending in health care continues to dominate political debate. The absence of consumer involvement in health care planning and allocation in Ireland is in direct contrast to the experience of many other OECD countries<sup>1</sup>. There is no consideration in the drafting of this legislation, that in core public services, service delivery is most appropriately seen as an outcome of relationships between all the key stakeholders and therefore the control system must reflect this complexity (McKevitt 1998).

Underlying all the difficulties that the Irish health service has, and is experiencing, is the focus on administrative control since the passing of the Health Act in 1970, the 1996 Health Amendment Act (introducing service planning) and now the Health Act of 2004. The health services need to be managed not administered. The health service had developed without a mission, a direction and underlying objective until 1994. However, the Health Strategies of 1994 and 2001 have never been properly implemented nor any of their principles given any impetus in legislation. According to the ESRI (2001) critique as a result of this, the issue of patient equity has continued to grow as a problem and there are copious reports regarding the growing crisis in Irish health care (Tormey 2003, O’Connor 2007, Burke 2009). It is evident that the DOHC has over the years been strong in the area of policy development. On the other hand, implementation of policy throughout the system has been poor and inconsistent.

In contrast in the Canadian case, not only are the principles for underpinning the planning and delivery of health services enshrined at federal level in the health system; at provincial level in the case of Nova Scotia the legislation allows for the setting up of Community Health Boards (CHBs). Under the Health Authorities Act, the CHB must prepare and submit to the District Health Authority (analogous to a health board/health region) a Community Health

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<sup>1</sup> For example; Canada (Community Health Boards), UK (Health Councils), Finland and Sweden (Health Councils), etc

Plan that includes recommended priorities for the delivery of community based health services and a list of the initiatives recommended by the CHB for the improvement of the health of the community (DOH 2002). The CHBs are each made up of fifteen volunteer members. The DHA is then required to take the Community Health Plan into consideration when preparing their yearly health-services business plan, and, should they fail to include the plans in their service planning, to publicly explain why. Therefore the CHBs operate in an advisory capacity to the DHA and the DHA's function is that of policy implementation and evaluation (DOH 1999). This has paved the way for needs based planning in the Nova Scotian health services, an aspect of planning that is notably absent in Irish health care planning. The legislation not only mandates community participation in health planning but it directs that the DHA administratively supports the work of the CHBs.

### **Implications; the NPM influence on Irish Policy**

In order to site this paper theoretically; the reform of the health services in Ireland as well as those in Canada can be seen as part of a wider set of public sector reforms which are characterized by the umbrella heading 'New Public Management' (NPM) (Hood 1991, 1995). Lapsley and Pallot (2000:215) acknowledge this broadly based international movement, which they describe as 'propelling public sectors of many economies towards convergence on how best to manage their activities'. Though, they also differentiate between intentions and consequences. The intention of NPM, according to Osborne and Gaebler (1992) being to make fundamental changes to management structures, processes and practices in the public sector. However, Lapsley and Pettigrew (1994) and Petterson (1995, 1999) have explored the consequences of NPM reforms in the public sector and in health care by deploying an institutional perspective to reveal the use of management or accounting practices mainly as legitimating devices. Since the mid 1980s and the 1990s (in the Irish case) the problem according to commentators (Pettigrew, Ferlie and McKee 1992, McKevitt 1998), has been the over mechanistic transfer of concepts from the private to the public sectors. Collins, Hunter and Green (1994) explain the drive for this type of public sector reform as the point having been reached where spending more money on health care was no longer an end in itself nor sustainable politically and therefore, issues of effectiveness and efficiency came to the fore. They blame this new orthodoxy of health reform on the rise of the 'new right' where the private sector is seen as more efficient at producing goods and services than the

public sector. It is a driver of health care reform in a diverse number of OECD countries including Ireland.

Dent, Howorth, Mueller and Preuschoft (2004) note, that while these NPM reform processes may vary in depth and scope they are remarkably similar in the goals they pursue and the technologies they utilize. There may be a number of different facets or ingredients to NPM, but some of the key features include: the move in focus from inputs towards outputs; a shift towards more measurement and quantification (performance indicators); a preference for more specialized lean, flat organisations (Pollitt and Talbot 2003); an increase in contract like relations; the use of markets; an emphasis on service quality and consumer orientation and a shift towards the values of efficiency and individualism (Hood 1991). In a given situation according to Pollitt (2003) the different NPM ingredients can exist from the ideas level to plans and strategies to accomplished processes and practices.

The UK, according to Jackson and Lapsley (2003), is seen as a country, which has been driven by reformers and modernisers and is viewed as a leader in the area of public sector reform. In that regard, it continues to be used as a model of reform by Irish policy makers. As a model, Pollitt and Bouckaert (2004:295) contend that UK reform has been continual, often intense and sometimes harsh. It has focused on privatisation and intensification of central target-setting, with contracting out and 'best value' initiatives. Yet, as Olson, Humphrey and Guthrie (2001) warn there are possible dangers in persisting with reform programmes under NPM with financial management as their focus. They argue that the pursuit of efficiency and effectiveness potentially results in fewer public services being provided at higher costs, described as the 'evaluatory trap'. For example in the Irish case, the development of information systems to gather non-financial information and outcomes has been extremely slow and piecemeal compared to the development of financial indicators. There is a drive to encourage private investment in the acute care sector with a business and financial focus, rather than to look at the root problems in the health care system. Thus, the focus has been on hard measurable performance indicators rather than measuring the real but less measurable outcomes from health service interventions. MacCarthaigh and Hardiman (2010) contend that some of the organisational and procedural changes in Irish public administration do bear similarities to those that would be expected as a result of adopting principles of NPM but due to the absence of strong political drivers the reform initiatives

haven't fundamentally altered the configuration of the Irish public administration. Boyle's (2010) interpretation of Irish style public management reform is that it has been driven more by pragmatism and less by any particular ideology. This may also explain the 'mixed messages' arising from health policy.

### **Control in Healthcare; Implementation of Policy**

In the Irish context, we have a national health strategy that is without legislative impetus. Unlike Canada and other European countries, Ireland has no legislated strategic framework that would provide for a control system responsive to the agreed health policy and guide the resource allocation process thus giving legitimacy to the resource decisions of healthcare managers. McKevitt (1990, 1998) notes that in official thinking on health care a heavy reliance is placed on structural and budgetary arrangements, which although important, reflect a tendency to seek solutions that are technical and operational in character. According to McKevitt (1997), this ensures that existing patterns of resource allocation and stakeholder relationships are maintained and as a result the planning process in health care becomes more susceptible to political influences, which are essentially short-term in nature, and do not provide for a strategic focus, nor can they reflect the underlying principles of the National Health Strategy.

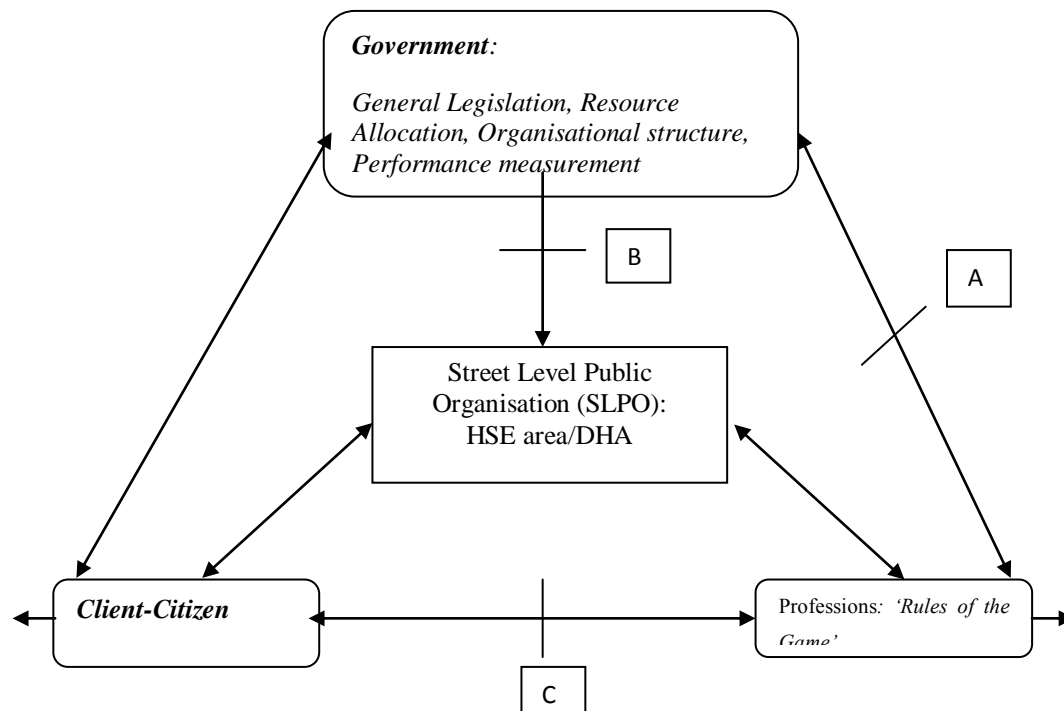
To reiterate the position taken in this paper; an examination of how policy is communicated in the health care arena the health service planning process can be used as an illustrative case. McKevitt (1998, 2000) argued that service delivery in core public services such as health care is most appropriately seen as an outcome of relationships between providers and the customer, client and citizen, involving a set of processes. His model of the Street Level Public Organisation (SLPO) can be used to explain the wider environmental context of health policy, planning, resource allocation as well as performance measurement systems. It takes into account the nature of a health care organisation which Mintzberg (1983) classifies as a professional bureaucracy and is characterised by many varied and competing groups. Such an organisation relies on the skills and knowledge of the operating professionals to function and to produce standard products or services. Millar and McKevitt (2000:291) assert that control in services dominated by professionals is a complex activity due to potential for conflicting demands and because the locus of control varies depending on the structural,

ethical and financial forces in that environment. In the rationing of resources, these professional specialists exercise discretion and in doing so, have considerable policy-making powers. Consequently, much of the organisational power resides at the bottom of the hierarchy. This raises a number of issues notably how this professional authority can be utilised in the planning of services. According to Wrigley and McKevitt (1995) the predominant source of power for these professionals over other stakeholders and in particular the citizen or client is that of differential information, as those with professional specialisms in health care have a greater knowledge in these areas than the mass of citizenry. As a result, the standards of the professional bureaucracy instead of being applied from above in terms of senior management, often originate from outside the structure from other operators that join with their colleagues in self-governing associations permeated by a variety of these external professional influences and norms that are not always reconcilable with efficiency objectives (DiMaggio and Powell 1991). Thus, the Street Level Public Organisation (SLPO) model allows for analysis of the heartland of public service delivery as well as identifying tensions that arise in the delivery of health care services due to different and competing interests (see Figure 1 overleaf). In order for the National Health Strategy's principles to gain purchase in this context, it must be legislated for as clearly as the financial and budgetary requirements are through the 2004 legislation.

### **Tensions in the Environment; Policy and Planning**

The importance of the SLPO model is that it allows consideration of whether there is consistency and coherence between espoused objectives at the national level, an overarching policy position, such as the aspirations of the national health strategy, and implementation at the point of service delivery, through the service planning process at local level. What is important in the health care context is that the model includes specific influences from the environment that affect service delivery in public organisations in particular. As Bovaird (2005) notes, service delivery in the public domain is no longer seen as a 'top down' process but should be seen as the negotiated outcome of many interacting systems with interactions with the 'users' of the services.

**Figure 1** Tensions in the SLPO environment



Source: Byers and McKevitt (2007) adapted from McKevitt (1998:99).

In the healthcare context the model accounts for the uneasy relationship between central government and professionals in the SLPO as well as their governing professional bodies. It allows for inclusion of the citizen-client. The model shows the important external relationships of the SLPO and these relationships impact directly or indirectly on the SLPO's capacity to deliver on policy. Thus, an understanding of the Health Board/DHA using McKevitt's model allows us to look at the implementation of the National Health Strategy. Looking to the SLPO model it can be noted that the immediate source of recurring tension is point A, relations between central government and the professions. There is a dual set of influences in operation in the SLPO. At government level there are a number of modes of influence; legislation, allocation of resources, organisational structure and performance measurement. Then there are the 'rules of the game', which are established by the professions and their associations. These two conflicting influences must be aligned otherwise according to McKevitt, Millar and Keogan (2000) the activities of the SLPO will run wild and undirected. With few exceptions, the normative literature on planning and management in health care, underlines the necessity for extensive participation by health professionals (Champagne 2002; Denis, Langley and Lozeau 1995; Peters, 1985), the main

argument being that implementation will be facilitated if people feel they were involved in decisions.

In using the SLPO model in this paper, it can be seen that to implement planning in the health services is not solely an organisational issue it has to account for control in a wider institutional context. The field work undertaken in the Irish context found that the national health strategy that should guide the strategic intent of health policy, underpinned as it is with the key principles of equity, accountability, people-centredness and quality had no outlet for its aspirations through the limits of the 2004 legislation. Therefore, the model of control was left at the level of budgets only, as per the legislation and it was unable to control for the effectiveness of service delivery. The legislation rather than facilitating the relationships between the key players in order to build up support, as originally envisaged in the SMI (from whence it came originally) (OECD 1999) was implemented to further distance these stakeholders, as evidenced by the findings of the fieldwork in the Irish context (see tension point A). Ultimately, due to the breakdown of relationships and trust between government/management and health professionals is the breakdown of the relationship with the citizen-client (see tension point C). This is unfortunately the result of a legislative framework that does not contain an explicit strategy to guide the resource allocation process in meeting the four key principles outlined. In contrast, the Canadian case legally mandated participation throughout the system in planning health care as well as legislating for the principles that underpinned delivery of these services. Thus, CHBs consult with their communities and community organisations. At the level above them there is consultation with key community, provincial and federal agencies. The DHA itself in its planning consults with the service users and clinicians in planning services as well as receiving the community feedback through the CHBs. The DOH consults with the DHA, and the political interests also have their say. Interviewees described a situation of a gradual building up of trust with the communities since the CHBs were mandated by legislation to input into the DHA health planning process. This was due in part to the clout they could wield because of the legislation but also to the skills of the teams themselves.



However, in Ireland at the present time, in contrast to the Canadian case, the debate about the crisis in health care centres on the government asserting that many of the problems relate to the poor performance of the health professions.

It is dealing with these tension points that should exercise government in the discharge of its planning obligations in health care, as these tensions will not dissipate without consideration of the complex environment of the SLPO. There is no one best way to reform core public services that will satisfy the needs of government, citizens and providers. Yet, in Ireland we have proceeded on the path to reform that ignores these differing needs and this is due in part to the belief that public organisations are similar in part to private organisations as per the NPM doctrine.

To summarise, McKevitt noted back in 1990 that there is a dual weakness in the Irish framework of strategic control and his observations are relevant to this analysis. Firstly, the legislation does not provide strategic objectives against which resource allocation and achievement of goals can be assessed and secondly there is inadequate monitoring of professional activity against appropriate policy objectives. This lack of linkage between the strategic and the operational increases the possibility that managing becomes an exercise in resource allocation unconnected with any overall strategy.

## **Conclusion**

At the outset, this paper posited that there were two key stumbling blocks to the successful implementation and communication of healthcare policy in Ireland which included the limitations of the legislation underpinning the planning and management of the health services and the lack of recognition of the complexity of the healthcare environment and the stakeholders within it. In the Irish case there is a 10 year old national health strategy without legislative impetus, thus ensuring that existing patterns of resource allocation and existing stakeholder relationships are maintained. Fieldwork in the Irish healthcare system identified these patterns. In contrast, in the Canadian case, it is the legislation at federal level articulating the basic principles for health services delivery and the legislation at provincial level mandating community involvement in the planning of services and underpinning its strategic management, that averts tensions and allows for needs assessment and health planning that is not vulnerable to the vagaries of political short-termism. McKevitt's (1998)

SLPO model aided the identification of the pressure or tension points that can occur in a milieu such as health when legislation only reflects budgetary imperatives and there is a lack of recognition of key stakeholders. This brings us back to O’Ferrall’s (2008) quote at the beginning of the paper; that a ‘democratic deficit’ exists in both the formulation and implementation of health policy. In contrast, the Canadian case is an exemplar of what can occur when all stakeholders are involved in the planning and delivery of healthcare.

According to Bourgon (2010) public sector administration has reached a crucial point in its development. It has to date offered prescriptions and recipes for planning and management that bear little relation to either practice or classical theory. Bourgon (2010) emphasizes the need for governments to build *resilience* in society. A resilient society is characterized by active citizenry and resilient communities. She goes on to note the importance of governments in tapping and harnessing the power of others through approaches that draw on collective intelligence, self organizing networks and distributed decision making. Her clarion call is echoed by other academics (Haarman, Klenk and Weyrauch 2010, Osborne 2010) that note that a turning point has been reached in public management and that the delivery of public services requires negotiation in inter-organizational relationships and multi-actor policy making processes. The Canadian case in this paper speaks to us of this approach.

In Irish healthcare management despite warnings about large scale importation of private sector principles, NPM style management remains fashionable. As Pollitt (2003) notes NPM is by no means over. So why, with concerns in the wider public arena, as well as the lessons outlined about the burgeoning inequities and costs in the US health care system due to its private sector management basis, does the NPM view or its pragmatic application continue to be the practice in Ireland, rather than the principles of our Health Strategy? As Tritter et al (2010) warn, values, principles and politics matter and they should emphasise patient or citizen-client voice, as it not only improves quality but creates an accountability mechanism in relation to needs assessment and service delivery. For Irish health care and for the citizen-client the choice to be made in healthcare reform should at least be made explicit through clear communication.

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